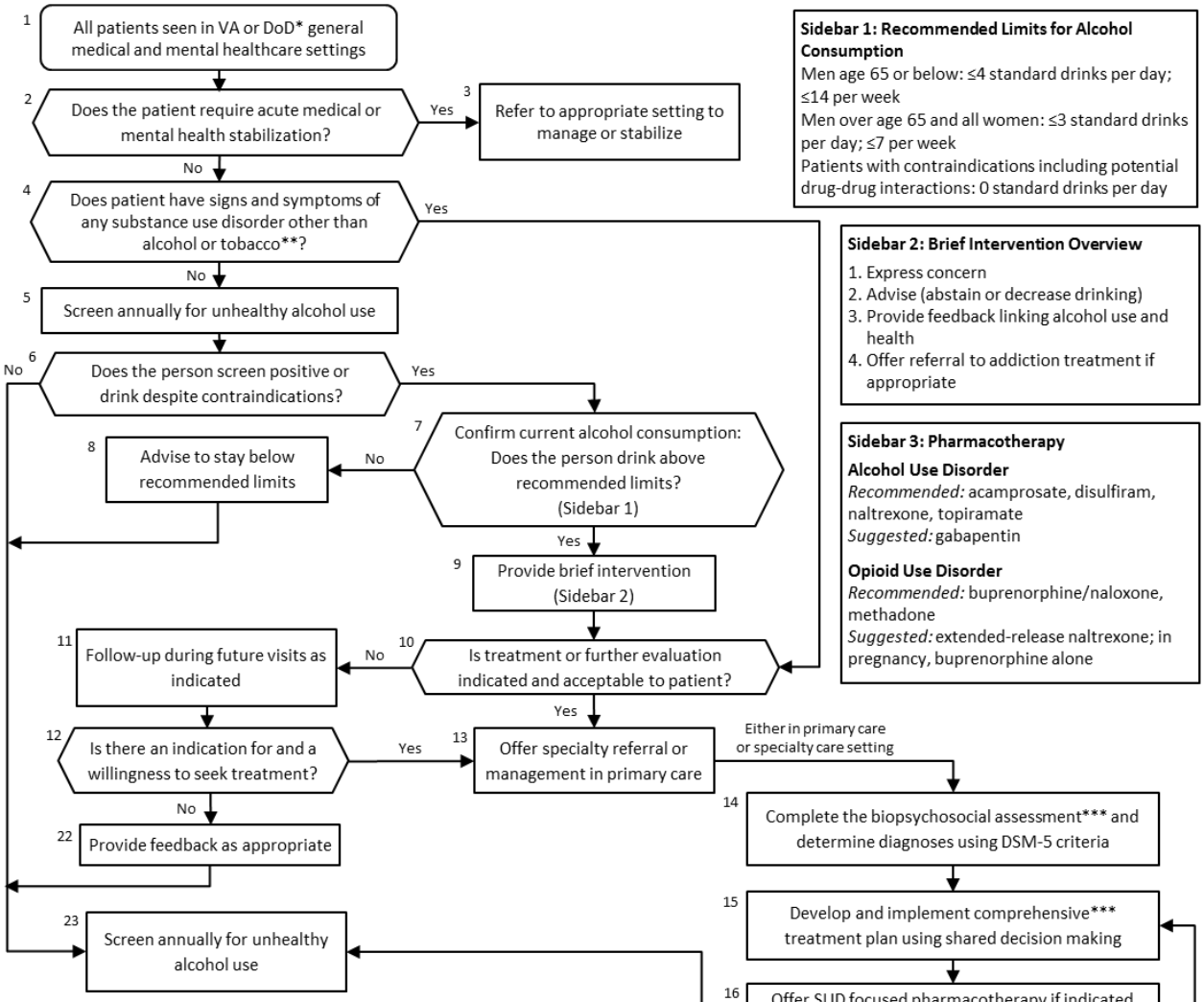
Screening and Treatment Pocket Card

Screening and Treatment Algorithm



Sidebar 1: Recommended Limits for Alcohol Consumption
Men age 65 or below: ≤4 standard drinks per day; ≤14 per week
Men over age 65 and all women: ≤3 standard drinks per day; ≤7 per week
Patients with contraindications including potential drug-drug interactions: 0 standard drinks per day

Sidebar 2: Brief Intervention Overview
1. Express concern
2. Advise (abstain or decrease drinking)
3. Provide feedback linking alcohol use and health
4. Offer referral to addiction treatment if appropriate

Sidebar 3: Pharmacotherapy

Alcohol Use Disorder
Recommended: acamprosate, disulfiram, naltrexone, topiramate
Suggested: gabapentin

Opioid Use Disorder
Recommended: buprenorphine/naloxone, methadone
Suggested: extended-release naltrexone; in pregnancy, buprenorphine alone

Sidebar 4: Components of Addiction-focused Medical Management
- Monitoring adherence, response to treatment, and adverse effects
- Education about AUD/OUD, health consequences, and treatments
- Encouragement to abstain from illicit opioids and other addictive substances
- Encouragement to attend and referral to community supports for recovery
- Encouragement to make lifestyle changes that support recovery

Sidebar 5: SUD and Co-occurring Conditions
- Refer to corresponding section of CPG on SUD and co-occurring conditions
- Consult other VA/DoD CPGs (e.g., Tobacco Use Disorder, Major Depressive Disorder, Posttraumatic Stress Disorder, Low Back Pain, Assessment and Management of Patients at Risk for Suicide, Chronic Multisymptom Illness, Concussion, Diabetes, Hypertension, Chronic Kidney Disease)

Abbreviations
AUD: alcohol use disorder; AUDIT-C: Alcohol Use Disorders Identification Test – Consumption; CPG: clinical practice guideline; DSM-5: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; DoD: Department of Defense; OUD: opioid use disorder; SUD: substance use disorders; VA: Department of Veterans Affairs

Symbols
*DoD Active Duty: Referral to Specialty SUD Care is required in any incident in which substance use is suspected to be a contributing factor. For refusal, contact Command to discuss administrative and clinical options.
**For patients with tobacco use disorder, refer to VA/DoD CPG on Tobacco Use.
***Specific to specialty care setting

<table>
<tr><th colspan="3">Screening Tools</th></tr>
<tr><th></th><th>Alcohol Use Disorders Identification Test- Consumption (AUDIT-C) Questions</th><th>Single-Item Alcohol Screening Questionnaire (SASQ)</th></tr>
<tr><td>When to use this tool</td><td>May be preferable in the following situations:
When the clinician preference is to obtain information regarding:
Any drinking (for those with contraindications)
Typical drinking (for medication interactions)
Episodic heavy drinking
Severity of unhealthy alcohol use provided by the AUDIT-C
When there is a specific service requirement
When an electronic medical record can score the AUDIT-C and provide decision support</td><td>Easier to integrate into clinician interviews</td></tr>
<tr><td>Items</td><td>1. How often did you have a drink containing alcohol in the past year?
Never — 0 point
Monthly or less — 1 point
2-4 times per month — 2 points
2-3 times per week — 3 points
4 or more times per week — 4 points
2. On days in the past year when you drank alcohol how many drinks did you typically drink?
0, 1, or 2 — 0 point
3 or 4 — 1 point
5 or 6 — 2 points
7-9 — 3 points
10 or more — 4 points
3. How often did you have 6 or more drinks on an occasion in the past year?
Never — 0 point
Less than monthly — 1 point
Monthly — 2 points
Weekly — 3 points
Daily or almost daily — 4 points</td><td>1. Do you sometimes drink beer, wine, or other alcoholic beverages?
(Followed by the screening question)
2. How many times in the past year have you had…
Men:
5 or more drinks in a day
Women:
4 or more drinks in a day</td></tr>
<tr><td>Scoring</td><td>The minimum score (for non-drinkers) is 0 and the maximum possible score is 12.
Consider a screen positive for unhealthy alcohol use if AUDIT-C score is ≥ 4 points for men or ≥ 3 points for women.</td><td>A positive screen is any report of drinking 5 or more (men) or 4 or more (women) drinks on an occasion in the past year.</td></tr>
</table>

Brief Intervention
Elements offered consistently as part of a brief intervention (BI): 1. Providing individualized feedback on patient's level of alcohol-related risk (i.e., mild, moderate, high) and any alcohol-related adverse health effects 2. Providing brief advice to abstain or drink within recommended limits Additional components: Discussion of benefits of and effective strategies for reducing alcohol consumption; supporting patient in choosing a drinking goal when he/she is ready to make a change

Criteria to Consider Referral to Specialty Care
A referral to specialty SUD care should be offered if the patient has at least one of the following: ▪ Potential benefit from additional evaluation of his/her substance use and related problems ▪ A substance use disorder diagnosis ▪ Willingness to engage in specialty care

Addiction-focused Medical Management

Addiction-focused Medical Management is a manualized psychosocial intervention designed to be delivered by a medical professional (e.g., physician, nurse, physician assistant) in a primary care (or general mental health care) setting. The treatment uses a shared decision making approach and provides strategies to increase medication adherence and monitoring of substance use and consequences, as well as supporting abstinence through education and referral to support groups. While variably defined, addiction-focused Medical Management typically includes:

1. Monitoring self-reported use, laboratory markers, and consequences
2. Monitoring adherence, response to treatment, and adverse effects
3. Education about alcohol use disorder (AUD) and opioid use disorder (OUD) consequences and treatments
4. Encouragement to abstain from illicit opioids and other addictive substances
5. Encouragement to attend community supports for recovery (e.g., Alcoholics Anonymous [AA], Narcotics Anonymous [NA], Self-Management and Recovery Training [SMART] Recovery) and to make lifestyle changes that support recovery

Session structure varies according to the patient's substance use status and treatment compliance. An initial session (40-60 minutes) includes assessment and initial treatment. Subsequent monitoring visits typically last 15-25 minutes and occur twice weekly for the first week, tapering to once weekly then once every two weeks for 12 weeks.

Pharmacotherapy for Alcohol Use Disorder (Diagnostic and Statistical Manual of Mental Disorders Diagnosis)

The table below is an abbreviated version of the table included in the full CPG. Please see Appendix B, Table B-1 for the full version of the table.

Naltrexone Oral	Naltrexone Injectable	Acamprosate	Disulfiram	Topiramate[1]	Gabapentin[1]
Indications[2]					
▪ AUD, pretreatment abstinence not required but may improve response	▪ AUD with difficulty adhering to oral regimen and willingness to receive monthly injections ▪ Pretreatment abstinence not required but may improve response	▪ AUD with abstinence at treatment initiation	▪ AUD with BAL=0, abstinence >12 hours, able to appreciate risks/benefits and consents to treatment ▪ Consider in patients with combined cocaine dependence	▪ AUD, pretreatment abstinence not required but may improve response	▪ AUD, pretreatment abstinence not required but may improve response
Contraindications[3]					
▪ Opioid-related findings,[4] acute hepatitis or liver failure	▪ Opioid-related findings,[4] acute hepatitis or liver failure, inadequate muscle mass	▪ Severe renal insufficiency (CrCl ≤30 mL/min)	▪ Severe cardiovascular, respiratory, or renal disease, hepatic dysfunction, and psychiatric disorders[5] ▪ Combination with metronidazole or ketoconazole	▪ No contraindications in manufacturer's labeling	▪ Known hypersensitivity to gabapentin or its ingredients

[1] Not FDA labeled for treatment of AUD

[2] Patients should be engaged in a comprehensive management program that includes psychosocial intervention; disulfiram is more effective with monitored administration (in clinic or with spouse or probation officer).

[3] Hypersensitivity to the agent is a contraindication to use for each medication listed.

[4] Receiving opioid agonists, physiologic opioid dependence with use within past seven days, acute opioid withdrawal, failed naloxone challenge test, or positive urine opioid screen are contraindications to oral or intramuscular naltrexone.

[5] Disulfiram is contraindicated in patients with severe and unstable psychiatric disorders (especially psychotic and cognitive disorders, suicidal ideation) and impulsivity.

Naltrexone Oral	Naltrexone Injectable	Acamprosate	Disulfiram	Topiramate[1]	Gabapentin[1]
Warnings/Precautions					
▪ Active liver disease ▪ Severe renal failure ▪ Pregnancy Category C	▪ Active liver disease ▪ Uncertain effects (no data) in moderate to severe renal insufficiency ▪ Use intramuscular injections with caution in patients at risk for bleeding ▪ Pregnancy Category C	▪ Watch for depression/ suicidality ▪ Decrease dose in renal insufficiency ▪ Pregnancy Category C	▪ Ensure adequate muscle mass for intramuscular injection ▪ Pregnancy Category C	▪ Footnote[6] ▪ Pregnancy Category D	▪ Footnote[6] ▪ Pregnancy Category C
Baseline Lab Evaluation- *Obtain urine beta-HCG for females*					
▪ Assess liver function	▪ Assess liver and renal function ▪ Ensure adequate muscle mass for intramuscular injection	▪ Assess renal function	▪ Assess liver function and electro-cardiogram ▪ Verify ethanol abstinence	▪ Assess renal function	▪ Assess renal function
Dosage and Administration					
▪ 50-100 mg orally 1 time daily	▪ 380 mg 1 time monthly by deep intramuscular injection	▪ 666 mg orally 3 times daily, preferably with meals	▪ 250 mg orally 1 time daily (range: 125–500 mg daily)	▪ Initiate at 50 mg daily ▪ Titrate gradually to max dose of 100 mg 2 times daily	▪ Initiate at 300 mg on day 1 and increase gradually by 300 mg daily to target of 600 mg 3 times daily

[6] Topiramate and gabapentin should not be abruptly discontinued; taper dosage gradually. Potential CNS effects may include dizziness, somnolence, cognitive dysfunction, and sedation. There is an increased risk of suicidal ideation with all anti-epileptic agents, including topiramate and gabapentin.

Naltrexone Oral	Naltrexone Injectable	Acamprosate	Disulfiram	Topiramate[1]	Gabapentin[1]
Alternative Dosing[7]					
▪ Footnote[7]		▪ Consider 333 mg orally 4 times daily for patients whose body weight is <60 kg	▪ Footnote[7]	▪ Footnote[7]	
Dosing in Special Populations					
▪ Use caution in hepatic or renal insufficiency	▪ No dose adjustment needed for CrCl 50–80 mL/min ▪ Uncertain effects (no data) in moderate to severe renal insufficiency	▪ Reduce dose by half when CrCl 30–50 mL/min ▪ Do not administer in severe renal insufficiency		▪ Halve dose and slow titrate when CrCl <70 mL/min/1.73 m^2 ▪ Dosage adjustment may be required in hepatic impairment	▪ Consider target dose <1800 mg daily when CrCl <60 mL/min
Adverse Effects					
▪ Common: Nausea ▪ Other: Headache, dizziness, nervousness, fatigue, insomnia, vomiting, anxiety, somnolence	▪ Major: Eosinophilic pneumonia, depression, suicidality ▪ Common: Injection-site reactions, nausea, headache, asthenia	▪ Major: Suicidality ▪ Common: Diarrhea ▪ Other: Anxiety, asthenia, depression, insomnia	▪ Major: Hepatotoxicity, peripheral neuropathy, psychosis, delirium, severe disulfiram-ethanol reaction ▪ Common: Somnolence, metallic taste, headache	▪ Major: Paresthesia, dizziness, somnolence, loss of appetite, weight loss ▪ Other: Nervousness, fatigue, decreased concentration, memory impairment, confusion	▪ Major: Dizziness, somnolence ▪ Other: Peripheral edema, fatigue

[7] Alternative dosing schedules as follows: For oral naltrexone, 25 mg 1-2 times daily with meals to reduce nausea, especially during the first week OR 100 mg on Monday and Wednesday and 150 mg on Friday. For disulfiram, decrease dose to 125 mg to reduce side effects and, for monitored administration, consider giving 500 mg on Monday, Wednesday, and Friday. For topiramate, in geriatric patients with CrCl <70mL/min/1.73m^2, give initial dose of 25 mg/day followed by incremental increases of 25 mg at weekly intervals until an effective dose is reached.

Naltrexone Oral	Naltrexone Injectable	Acamprosate	Disulfiram	Topiramate[1]	Gabapentin[1]
Drug Interactions					
▪ Opioid-containing medications, thioridazine	▪ Opioid-containing medications, thioridazine	▪ Naltrexone, antidepressants	▪ Meds and other alcohol-containing products, phenytoin, isoniazid, warfarin, monoamine oxidase inhibitors, rifampin, tricyclic antidepressants, metronidazole	▪ Combination with alcohol or other CNS depressants, oral contraceptives	▪ Combination with alcohol or other CNS depressants, antacids
Monitoring					
▪ Repeat liver transaminase levels at 6 and 12 months and then every 12 months thereafter ▪ Discontinue medication and consider alternatives if no detectable benefit after an adequate trial (50 mg daily for 3 months)	▪ Repeat liver transaminase levels at 6 and 12 months and then every 12 months thereafter ▪ Discontinue if there is no detectable benefit within 3 months	▪ Monitor renal function especially in elderly and in patients with renal insufficiency ▪ Maintain therapy if relapse occurs	▪ Repeat liver transaminase levels within the first month, then monthly for first 3 months, and periodically thereafter as indicated ▪ Consider discontinuation in event of relapse or when patient is not available for supervision and counseling	▪ Monitor renal function (especially in elderly and in patients with renal insufficiency) and for behavioral changes indicative of suicidal thoughts or depression ▪ Discontinue medication and consider alternatives if no detectable benefit after an adequate trial (300 mg daily for 3 months)	▪ Monitor renal function (especially in elderly and in patients with renal insufficiency) and for behavioral changes indicative of suicidal thoughts or depression ▪ Monitor quantities prescribed and usage patterns ▪ Discontinue medication and consider alternatives if no detectable benefit from at least 900 mg daily for 2-3 months

<table>
<tr><th>Naltrexone Oral</th><th>Naltrexone Injectable</th><th>Acamprosate</th><th>Disulfiram</th><th>Topiramate[1]</th><th>Gabapentin[1]</th></tr>
<tr><td colspan="6">Patient Education</td></tr>
<tr><td>■ Focus on patient compliance and commitment to treatment plan
■ Side effects occur early and typically resolve within 1-2 weeks after dosage adjustment</td><td>■ Report injection-site reaction, any new or worsening depression/suicidal thinking
■ Contact provider for signs/symptoms of pneumonia</td><td rowspan="2">■ Report any new or worsening depression/suicidal thinking</td><td rowspan="2">■ Avoid alcohol in food, beverages, and medications
■ Avoid disulfiram if alcohol intoxicated
■ May cause sedation
■ Discuss compliance enhancing methods and provide wallet cards
■ Family members should not administer disulfiram without informing patient</td><td rowspan="2">■ Bitter tablets
■ Do not crush, break or chew
■ Take without regard to meals
■ May cause sedation or decreased alertness</td><td rowspan="2">■ Take first dose on first day at bedtime to minimize somnolence and dizziness
■ May cause sedation or decreased alertness</td></tr>
<tr><td colspan="2">■ If signs/symptoms of acute hepatitis occur, stop naltrexone and contact provider immediately
■ Very large doses of opioids may overcome naltrexone effects and result in injury, coma, or death
■ Opioid-based analgesics, antidiarrheals, or antitussives may be blocked by naltrexone and fail to produce effect
■ Patients who have previously used opioids may be more sensitive to toxic effects of opioids after discontinuation of naltrexone</td></tr>
</table>

Abbreviations: AUD: alcohol use disorder; BAL: blood alcohol level; CNS: central nervous system; CrCl: creatinine clearance; kg: kilogram(s); m: meter(s); mg: milligram; mL: milliliter(s); min: minute(s)

Pharmacotherapy for Opioid Use Disorder (Diagnostic and Statistical Manual of Mental Disorders Diagnosis)

The table below is an abbreviated version of the table included in the full CPG. Please see Appendix B, Table B-2 for the full version of the table.

Methadone	Buprenorphine/Naloxone or Buprenorphine	Naltrexone Injectable
Indications		
▪ OUD and patient meets Federal OTP Standards (42 C.F.R. §8.12)	▪ OUD	▪ OUD with pretreatment abstinence from opioids and no signs of opioid withdrawal; willingness to receive monthly injections
Contraindications		
▪ Hypersensitivity	▪ Hypersensitivity	▪ Hypersensitivity ▪ Opioid-related findings[1] ▪ Acute hepatitis or liver failure ▪ Inadequate muscle mass
Warnings/Precautions		
▪ Concurrent enrollment in another OTP ▪ Prolonged QTc interval ▪ Footnote[2]	▪ Buprenorphine/naloxone and buprenorphine may precipitate withdrawal in patients on full agonist opioids ▪ Footnote[2]	▪ Active liver disease ▪ Uncertain effects (no data) in moderate to severe renal insufficiency ▪ Use intramuscular injections with caution in patients at risk for bleeding ▪ Pregnancy Category C
Baseline Evaluation- *Obtain urine beta-HCG for females*		
▪ Baseline electrocardiogram and physical examination for patients at risk for QT prolongation or arrhythmias	▪ Liver transaminases	▪ Assess liver and renal function ▪ Ensure adequate muscle mass for intramuscular injection

[1] Receiving opioid agonists, physiologic opioid dependence with use within past seven days, acute opioid withdrawal, failed naloxone challenge test, or positive urine opioid screen are contraindications to intramuscular naltrexone

[2] Use caution in patients with 1) Respiratory, liver, or renal insufficiency 2) Concurrent benzodiazepines or other CNS depressants including active AUD 3) Use of opioid antagonists (e.g., parenteral naloxone, oral or parenteral nalmefene, naltrexone)

Methadone	Buprenorphine/Naloxone or Buprenorphine	Naltrexone Injectable
Dosage and Administration		
▪ Give as single daily oral dose; individualize dosing ▪ Titrate carefully; consider methadone's delayed cumulative effects ▪ *Initial dose:* 15–20 mg single dose, maximum 30 mg ▪ *Daily dose:* Maximum 40 mg/day on first day ▪ *Usual dosage range for optimal effects:* 60–120 mg/day	▪ Individualize dosing regimens ▪ For any formulation: Do not chew, swallow, or move after placement ▪ *Sublingual induction dose:* 2–8 mg once daily. Day 2 and onward: Increase dose by 2–4 mg/day until withdrawal symptoms and craving are relieved ▪ *Sublingual stabilization/ maintenance dose:* Titrate by 2–4 mg/day targeting craving and illicit opioid use ▪ *Sublingual usual dose:* 12–16 mg/day (up to 32 mg/day)	▪ 380 mg 1 time monthly by deep intramuscular injection
Alternative Dosing Schedules		
▪ Give in divided daily doses based on peak and low levels that document rapid metabolism	▪ Give equivalent weekly maintenance dose divided over extended dosing intervals (every 2, 3, or 4 days)	
Dosing in Special Populations		
▪ Reduce dose in renal or hepatic impairment and in the elderly or debilitated	▪ Hepatic impairment: Reduce dose ▪ For concurrent chronic pain, consider dividing total daily dose into 2- or 3-time daily administration	▪ No dosage adjustment needed for CrCl 50-80 mL/min ▪ Uncertain effects (no data) in moderate to severe renal insufficiency
Adverse Effects		
▪ Major: Respiratory depression, shock, cardiac arrest, prolongation of QTc interval/torsade de pointes/ventricular tachycardia ▪ Common: Lightheadedness, dizziness, sedation, nausea, vomiting, sweating, constipation, edema ▪ Less common: Sexual dysfunction	▪ Major: Hepatitis, hepatic failure, respiratory depression (with intravenous misuse or combined with other CNS depressants) ▪ Common: Headache, pain, abdominal pain, insomnia, nausea and vomiting, sweating, constipation ▪ Sublingual buprenorphine/ naloxone: Oral hypoesthesia, glossodynia, oral mucosal erythema	▪ Major: Eosinophilic pneumonia, depression, suicidality ▪ Common: Injection site reactions, nausea, headache, asthenia

Methadone	Buprenorphine/Naloxone or Buprenorphine	Naltrexone Injectable
Drug Interactions		
■ ↓ Methadone levels: Footnote[3] ■ ↑Methadone levels: Footnote[4] ■ Opioid antagonists: May precipitate withdrawal	■ ↓ Buprenorphine levels: Footnote[3] ■ ↑ Buprenorphine levels: Footnote[4] ■ Opioid agonist: buprenorphine/naloxone or buprenorphine may precipitate withdrawal ■ Opioid antagonists: May precipitate withdrawal	■ Opioid-containing medications ■ Thioridazine
Monitoring		
■ Signs of respiratory/CNS depression	■ Liver function tests prior to initiation and during therapy	■ Repeat liver transaminase levels at 6 and 12 months and every 12 months thereafter
Patient Education		
■ Give strong advice against self-medicating with CNS depressants during methadone therapy; serious overdose and death may occur ■ Store in a secure place out of the reach of children ■ Strongly advise patient to continue in long-term methadone maintenance ■ If discontinuing methadone, recommend transition to extended-release injectable naltrexone ■ Serious overdose and death may occur if patient relapses to opioid use after withdrawal from methadone	■ Give strong advice against self-medicating with CNS depressants during buprenorphine/naloxone or buprenorphine therapy; serious overdose and death may occur ■ Store in a secure place out of the reach of children ■ Strongly advise patient to continue in long-term buprenorphine maintenance ■ If discontinuing buprenorphine, recommend transition to extended-release injectable naltrexone ■ Serious overdose and death may occur if patient relapses to opioid use after withdrawal from buprenorphine	■ Report any injection site reactions, new or worsening depression, or suicidal thinking ■ Contact provider for signs and symptoms of pneumonia ■ If signs and symptoms of acute hepatitis occur, discontinue naltrexone and contact provider immediately ■ Very large doses of opioids may overcome the effects of naltrexone and lead to serious injury, coma, or death ■ Opioid-based analgesics, antidiarrheals, or antitussives may be blocked by naltrexone and fail to produce effect ■ Patients who have previously used opioids may be more sensitive to toxic effects of opioids after discontinuation of naltrexone

Abbreviations: CNS: central nervous system; CrCl: creatinine clearance; IV: intravenous; mg: milligram(s); OTP: Opioid Treatment Program; OUD: opioid use disorder; QTc: the heart rate corrected time from the start of the Q wave to the end of the T wave

[3] Drugs that decrease methadone or buprenorphine levels: Ascorbic acid, barbiturates, carbamazepine, ethanol (chronic use), interferon, phenytoin, rifampin, efavirenz, nevirapine, other antiretrovirals with CYP3A4 activity

[4] Drugs that increase methadone or BUP levels: Amitriptyline, atazanavir, atazanavir/ritonavir, cimetidine, delavirdine, diazepam, fluconazole, fluvoxamine, ketoconazole, voriconazole

Psychosocial Interventions for Substance Use Disorders

Recommended Psychosocial Interventions by Substance Use Disorder			
For patients with any substance use disorder, choice of psychosocial intervention should be made considering patient preference and provider training/competence.			
Alcohol Use Disorder	**Opioid Use Disorder**	**Cannabis Use Disorder**	**Stimulant Use Disorder**
▪ Behavioral Couples Therapy for alcohol use disorder ▪ Cognitive Behavioral Therapy for substance use disorders ▪ Community Reinforcement Approach ▪ Motivational Enhancement Therapy ▪ 12-Step Facilitation	▪ **For patients in office-based buprenorphine treatment:** Addiction-focused Medical Management with choice of psychosocial intervention based on patient preference and provider training/competence ▪ **For patients in OTP:** Individual counseling and/or Contingency Management	▪ Cognitive Behavioral Therapy ▪ Motivational Enhancement Therapy ▪ Combined Cognitive Behavioral Therapy/Motivational Enhancement Therapy	▪ Cognitive Behavioral Therapy ▪ Recovery-focused behavioral therapy • General Drug Counseling • Community Reinforcement Approach ▪ Contingency Management in combination with one of the above

Abbreviation: OTP: Opioid Treatment Program

Suggested Patient Resources

In addition to the VA/DoD SUD CPG patient summary, consider referring patients to the following resources (also included in the patient summary):

- Department of Veterans Affairs:
  - Treatment Programs for Substance Use Problems: http://www.mentalhealth.va.gov/substanceabuse.asp
  - Substance Use Disorder Program Locator, which will help you find local VA Substance Use Disorder Treatment Programs: http://www.va.gov/directory/guide/SUD_flsh.asp?isFlash=1
- Substance Abuse and Mental Health Services Administration: http://www.samhsa.gov/atod
  Toll-free Number: 1-877-SAMHSA-7 (1-877-726-4727)
  For a teletype device (TTY): 1-800-487-4889
- National Institute on Alcohol Abuse and Alcoholism (NIAAA)'s resources:
  Toll-free Number: 1-800-662-HELP (4357)
  For a teletype device (TTY): 1-800-487-4889
  - Rethinking Drinking: http://rethinkingdrinking.niaaa.nih.gov/Default.aspx
  - Treatment for Alcohol Problems: Finding and Getting Help: http://pubs.niaaa.nih.gov/publications/Treatment/treatment.htm
- Seeking Drug Abuse Treatment: Know What To Ask: http://www.drugabuse.gov/publications/seeking-drug-abuse-treatment-know-what-to-ask/introduction
- Alcoholics Anonymous: http://www.aa.org/
- Narcotics Anonymous: https://www.na.org/
- SMART Recovery: http://www.smartrecovery.org/
- Smoke Free Vet: www.smokefree.gov/vet/